STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING: _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

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4 000	Initial Comments A re-licensure survey was conducted on April 3, 2018 through April 6, 2018. A census of 22 was reported when the surveyors entered the facility.	4 000		
4 101	11-94.1-22(c) Medical record system (c) The following information shall be obtained and entered in the resident's record at the time of admission to the facility: (1) Personal information such as name, date, and time of admission, date and place of birth, citizenship status, marital status, social security number, or an admission number that can be used to identify the resident without use of name when the latter is desirable; (2) Name and address of next of kin, legal guardian, surrogate, or representative holding a power of attorney; (3) Sex, height, weight, race, and identifying marks; (4) Reason for admission or referral; (5) Language spoken and understood; (6) Information relevant to religious affiliation, if any; (7) Admission diagnosis, summary of prior medical care with listing of physicians providing care, recent physical examination, tuberculosis status, and physician's orders; and (8) Advanced directives, as applicable.	4 101		5/8/18

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/10/18

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4 101	Continued From page 1 This Statute is not met as evidenced by: Based on record review, staff and resident interview, facility failed to accurately document advance directive information for 2 of 19 residents (residents (R) 12 and 16) sampled for investigations. Findings Include: 1) Record Review (RR) on 04/04/18 at 08:06 AM revealed R16's Provider Orders for Life-Sustaining Treatment (POLST) form, prepared on 1/20/18, checked off in section A to "Attempt Resuscitation/CPR", in section B to "Full treatment" and in section C "Defined trial period of artificial nutrition by tube" with a "Goal: until recovered." R16's code status, on her profile page of the Electronic Medical Record (EMR) reflected what was on R16's POLST. Upon further RR it was found that R16 also had an Instructions for Health Care (Living Will Declaration) and Durable Power of Attorney (POA) for Health Care Decisions dated 9/20/2000 which conflicted with her POLST. R16's Living Will Declaration and Durable POA specifies "(a) Choice Not to Prolong Life. I do not want my life prolonged if: (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness or (iii) the likely risks and burdens of treatment would outweigh the expected benefits..." It was noted that under the "Artificial Hydration and Nutrition" section of the Living Will Declaration R16 chose "I do not want my life prolonged by artificial nutrition and hydration if my condition is as stated above and regardless of the choice I have made in paragraph (1)." R16 signed the Living Will Declaration and Durable POA on	4 101	1. A. Resident R12's advance directives was discussed with the resident on 04/04/18. Resident has requested additional time to consider which is reflected in the Social Services progress notes. B. Resident R16's advance directives and POLST are per resident's wishes and documented in the medical record. 2. Residents residing in the facility have the potential to be affected. An audit was conducted by the Social Services Director on advance directives and POLST. Residents who requested an advance directive, the information has been provided to the resident and responsible party. Should they need assistance, the Social Services Director/Designee will assist as needed. 3. Training was provided to the Social Services Director on 05/02/18 by the Social Services Consultant regarding advance directives and POLST to include informing the resident if there is a conflict between documents and documenting advance directives in the electronic medical record (PCC). 4. Health Information Manager/Designee will audit 3 medical records x 2 weeks for one month, then 3 medical records per month x 2 months to verify that residents received advanced directive information and it is accurately documented and	

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4 101	Continued From page 2 9/20/2000 and the POLST form, which was prepared on 1/20/2018. On 04/05/18 at 11:12 AM interviewed Staff (S) 5, who was assigned to work with R16 that day, and S5 confirmed that they would perform CPR if R16 was found unresponsive, and this decision was based on R16's preference that was on her POLST and Code Status that was also on R16's profile page in the EMR. On 04/05/18 at 03:31 PM met with R16 and inquired about her POLST and Living Will Declaration and Durable POA, that there is a conflict with the two. R16 stated that she "signed the POLST...with the nurse" that day. On 04/05/18 at approximately 3:45 PM met with S25 to inquire about conflict with R16's POLST and Living Will Declaration and Durable POA. S25 explained that the POLST was filled out on admission and that S25 was not aware of the conflict of the POLST and Living Will Declaration and Durable POA until recently and R16's POLST was updated that day (04/05/2018) to reflect what is in R16's Living Will Declaration and Durable POA and just needed to be signed by the doctor. 2) RR on 04/04/18 at 09:30 AM revealed that R12 did not have documentation of an advanced directive. S25 stated in an interview on 04/04/18 at 10:23 AM that information was shared with R12 and that the resident refused an advanced directive although it was offered. S25 further stated that she did not document her conversation with R 12. The facility failed to accurately document information for R16 and R12 that could affect the	4 101	conflicts have been addressed. DON/Designee will report findings to QAA/QAPI committee monthly x 3 months or until a lesser frequency is deemed appropriate. 5. The Health Information Manager is responsible for compliance. 6. Compliance will be achieved by 05/08/18.	

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4 101	Continued From page 3 care they wish to receive.	4 101		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to monitor a nourishment refrigerator's freezer temperature where the resident's ice cream and magic cups were stored. Findings Include: On 04/05/18 at 08:35 AM while checking the nourishment room, opened the refrigerator freezer door and found that there was 1 gallon container of ice cream and multiple magic cups. During this time noted that there was no thermometer for the freezer and the temperatures for this freezer was not being logged on a monitoring sheet. On 04/05/18 before lunch, interviewed the DON and staff 42 who confirmed that there was no thermometer in the nourishment room refrigerator freezer and that the staff had not been monitoring	4 159	1. No resident was named in the 2567. 2. Residents residing in the facility have the potential to be affected. On 04/05/18 facility staff validated that a thermometer was in the refrigerator freezer. A temperature log was also started. 3. DON/Designee educated licensed nurses on the following: thermometer to be in nourishment refrigerator freezer when there is food items and record temperatures. 4. DON/Designee will conduct walking rounds weekly for one month, then monthly x 2 months to validate	5/8/18

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4 159	Continued From page 4 the temperature. The potential for foodborne illness exists for the nursing home residents as the facility failed to monitor food at correct temperatures.	4 159	thermometer is in nourishment refrigerator freezer and temperature is being recorded. DON/Designee will report findings to QAA/QAPI committee monthly x3 months or until a lesser frequency is deemed appropriate. 5. The DON will be responsible for compliance. 6. Compliance will be achieved by 05/08/18.	
4 173	11-94.1-43(a) Interdisciplinary care process (a) A comprehensive assessment shall be completed for each resident by an interdisciplinary team at least annually and updated as appropriate, based on the resident's condition. This Statute is not met as evidenced by: Based on electronic medical record (EMR) reviews, observations and interviews, the facility did not identify in a timely manner a significant change in weight (wt) for 1 of 19 residents (Resident (R) 8) sampled for investigation. Findings Include: On 04/04/18 at 09:35 AM, reviewed R8's EMR and noted that she was admitted on 05/18/17 with weight at 142.2 lbs. The care plans (CP) included, nutrition, and that a nutritional problem or potential nutritional problem for R8 who was on a therapeutic diet and had variable intake at risk	4 173	1. The Registered Dietician (RD) reassessed the nutritional status for Resident R8 and results are documented in the medical record. 2. Residents residing in the facility have the potential to be affected. Residents with weight variances have been identified and weights are being addressed in weekly weight and skin meetings. The meetings will be held until weight goal is achieved as addressed in nutrition care plan. A. The facility has two methods of	5/8/18

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4 173	Continued From page 5 for wt loss due to dysphagia and on a mechanically altered diet. The goals were for no significant wt loss of 5% in 30 days or 10% in 180 days. In 180 days (11/18/17) R8 weighed 128.6 lbs that was calculated (LTCSP software calculator) at a 10% wt loss; and, had a current (03/03/18) wt of 127.6 lbs. On 04/05/18 at 08:54 AM observed R8 eating breakfast and Staff 18 documented 75-100% intake at breakfast, and stated that R8 received insulin for diabetes mellitus (DM2) at 8:00 AM. On 04/06/18 at 08:23 AM, reviewed R8's EMR and the minimum data set (MDS) 3.0 dated 11/22/17 had the Nutrition section completed by Staff 3. The resident's wt was at 129 lbs and "No" was marked for wt loss (loss of 5% or more in the last month or loss of 10% or more in last 6 months). On 04/06/18 at 08:41 AM interviewed Staff (S)3 and inquired whether R8 was being monitored for wt loss since admission on 5/18/17. S3 stated that R8 was monitored every week up until Nov 2017 and R8 "pretty stable." When RD started working at facility (June 2017), R8 was eating well and ate 76-100% of meals; didn't want any supplements and was happy with the food. The licensed staff did skin and weight checks weekly and R8 had gradual weight loss; still within ideal body weight. S3 stated that the facility's policy and procedure (P&P) is that the dietitian would inform nursing if noticed that 10% wt loss in 6 months and licensed nurse would inform the MD. S3 stated that weights are watched closely if any resident	4 173	calculating weights. One method - the weight coded in the MDS looking at a specific time range per RAI instructions and is not used to calculate weight variances. Second method - The weights recorded in the electronic medical record, Point Click Care (PCC). This is the weight that the facility will use to calculate weight variances triggers on 3% (week to week), 5% in one month, 7.5% in 3 months and 10% in 6 months. B. The Clinical Reimbursement Services (CRS) trained the MDS Coordinator on 5/2/18 on how to calculate weight variances accurately in the MDS as instructed in the RAI manual. In addition, the Director of Nursing (DON)/Designee will use the weight variance report in Point Click Care (PCC). If weights are triggered week to week and/or monthly, the weight will be addressed by the IDT in a timely manner. 3. The CRS/Designee will audit MDS weight section: 3 MDS□ every 2 weeks for 30 days, and then 2 MDS□ monthly for the next 60 days. In addition, monthly, the DON/Designee will audit 2 residents who trigger 3% (week to week) 5% in one month, 7.5% in 3 months, or 10% in 6 months to validate calculation is correct and weight variances are addressed timely. MDS/DON/Designee will report findings to QAA/QAPI committee monthly x 3 months or until a lesser frequency is deemed appropriate. 4. The MDS will be responsible for	

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4 173	Continued From page 6 has pressure injuries and/or weight changes. S3 further stated that on 11/01/17, R8 had an RD consult for 3% wt loss from Oct to Nov, on a liberalized diet, and that her lab values that measured control of blood glucose levels (HgbA1c) were within normal limits. On 04/06/18 at 10:36 AM interviewed S96 and she looked at a different snapshot period in MDS and used the assessment reference date (ARD) for the three month look back period and didn't look back to the admission date weight. S96 also counted from June to November as 6 month period from admission, and the admission nutritional screen dated 5/19/17, had a BMI 21 or greater for R8.	4 173	compliance. 5. Compliance will be achieved by 05/08/18.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on resident interview, record review and staff interview the facility failed to develop and implement a baseline care plan for anemia or bleeding for 1 of 19 residents (Resident (R) 16) sampled for investigation. Findings Include: On 04/03/18 at 03:05 PM interviewed resident (R) 16 and she reported that she had a bleed from	4 174	1. The comprehensive care plan on Resident R16 has been updated and includes medical diagnoses and if indicated, signs and symptoms to monitor. 2. Residents residing in the facility have the potential to be affected. Initial care plans will be implemented within 48 hours of admission and during care plan reviews	5/8/18

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4 174	Continued From page 7 his/her rectum in late January from diverticulosis and was hospitalized. Record review (RR) of R16 Electronic Medical Record (EMR) found that R16 was admitted on 01/19/18, transferred from an acute hospital, with a diagnosis of post hemorrhagic anemia as a secondary diagnosis from a right shoulder fracture. It was noted, in discharge forms from the acute hospital, that R16 had developed worsening severe fracture-associated blood loss anemia and received one unit packed red blood cells (PRBCs). Review of R16's Care Plan (CP), dated from 01/19/18, did not list anemia or bleeding as a problem and no interventions were listed. Review of R16 Minimum Data Set (MDS) Admission Assessment dated 01/26/18 had anemia listed as an active diagnosis. RR of R16's lab results dated 01/22/18 at 8:25 AM found Hemoglobin low at 9.6 g/dL (normal 11.6-15.1 g/dL<5.7) and Hematocrit low at 30.7% (normal 34.1-44.2 %). Review of progress note dated 01/31/18 at 4:57 AM found that R16 had a bleed from resident's rectum with clots which was self-reported. It was documented that staff assessed R16 for pain, bleeding ..., positive bowel sounds, and paged on call Medical Doctor (MD). Doctor returned the phone call and gave orders for labs to be done immediately (STAT) for Complete Blood Count (CBC) with differential and Basic Metabolic Panel (BMP), hold AM dose of aspirin, ferrous sulfate, tecagrelor, Metoprolol and senna and to notify MD regarding resident's condition before starting the next dose that day. It was noted that there was an additional order to start orthostatic vital signs x1. BMP was collected on 01/31/2018 at 5:38 AM. Lab results for Hemoglobin was still low at 9.8 g/dL (normal 11.6-15.1) and Hematocrit was also still low at	4 174	to include diagnosis and if indicated, signs and symptoms to monitor. 3. Clinical Reimbursement Services (CRS)/Designee educated the MDS coordinator on 05/02/18 on creating a baseline care plan within 48 hours of resident's admission and to include medical diagnoses and if indicated, signs and symptoms to monitor. 4. DON/Designee will conduct audits on 3 residents every 2 weeks for one month, then 3 residents per month x 2 months to validate that resident's baseline care plans are completed within 48 hours of admission. DON/Designee will report findings to QAA/QAPI committee monthly x 3 months or until a lesser frequency is deemed appropriate. 5. The DON will be responsible for compliance. 6. Compliance will be achieved by 05/08/18.	

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4 174	Continued From page 8 30.9% (normal 34.1-44.2 %). Review of lab results found that they were signed by staff and dated 2/1/18. Hemoglobin and Hematocrit lab was collected on 2/1/18 at 8:45 AM and "critical notification pending report" was dated 02/01/18 at 4:19 PM with the following results for Hemoglobin at critical low of 7.7 g/dL (normal 11.6-15.1) and Hematocrit at critical low of 25.2% (normal 34.1-44.2%). The lab results were noted by facility staff. R16 was sent to the acute hospital Emergency Room (ER) for treatment and discharged from the facility from 02/01/18 and returned on 02/09/18. On 04/05/18 at 11:28 AM interviewed Director of Nursing (DON) who confirmed that she could not find CP for anemia in R16's EMR. DON stated that she would follow up with the facility's MDS coordinator to see if they could find anything on initial CP for this resident for anemia. No further information or CP was provided by DON. On 04/05/18 at 03:46 PM interviewed MDS coordinator who confirmed that R16's EMR did not have anemia or bleeding as a problem in the resident's initial care plan. MDS coordinator confirmed that R16 had anemia as an active diagnosis upon admission and this was coded on R16's MDS Admission Assessment dated 01/26/18. Inquired why anemia was not care planned for and MDS coordinator stated that she felt that the anemia was a result from post-op surgery from fracture repair and did not need care planning. The potential to adversely affect R16 exists due to lack of baseline CP for anemia or bleeding if staff, who are unfamiliar with resident, are assigned to work with her.	4 174		

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4 175	Continued From page 9	4 175		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to develop a person-centered care plan to maintain the resident's highest physical well-being for 2 of 19 residents (Resident (R) 15 and 170) sampled for investigation. Findings Include: 1) On 04/04/18 at 11:04 AM during record review (RR) it was noted that R15 was admitted to the facility on 02/22/2018 with the following diagnoses: sepsis, wedge compression fracture of first lumbar vertebra, other secondary thrombocytopenia, unspecified dementia without behavioral disturbance, chronic pain, unspecified macular degeneration, essential (primary) hypertension, supraventricular tachycardia, cellulitis of left upper limb, osteoporosis, malaise and history of falling. On 03/06/2018 R15 had the following diagnoses added anorexia and abnormal weight loss. Review of R15's weights found that she weighed 159.4 pounds on admission (02/22/2018) and weighed 136.4 pounds on 03/24/18 which was a 14.43% weight loss in 31 days. Noted that R15 had a documented "Significant Weight Change" on 03/05/2018 on her Skin and Weight Assessment which was dated 03/05/2018 at	4 175	1. A. Nutrition care plan was reviewed for R15. The Ideal Body Weight (IBW) and estimated energy requirement is documented in the Nutritional Evaluation, which is the facility protocol. B. The oxygen care plan was reviewed and updated for R170 to include interventions to monitor oxygen saturation by following physician orders. The oxygen saturation parameters will be documented in the treatment administration record (TAR). 2. Residents residing in the facility have the potential to be affected. The IBW and estimated energy requirements are located in the Nutritional Evaluation in Point Click Care (PCC). Current residents with oxygen orders include parameters and oxygen saturations which is in the TAR. 3. DON/Designee in-serviced licensed nurses on identification of significant weight loss and action steps; where to locate the IBW and energy requirement for residents; and obtaining oxygen	5/8/18

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4 175	Continued From page 10 13:46. The "Significant Weight Change" was not an anticipated weight change and documented as unavoidable with the following explanation "Resident with significant weight loss of 19.4# (12%) x1 week. Resident with reduced intake since admission, multiple supplements added. Large weight change ?accuracy (sic) however some weight loss likely due to decreased intake." Review of R15's Care Plan (CP) found that resident had "Name has poor intake and is at risk for weight loss" which was initiated on 02/22/2018 and revised on 03/21/2018. Goal for this problem was "No significant weight loss of 5% in 30 days or 10% in 180 days" which was initiated on 02/23/2018 with a target date of 05/22/2018. R15 also had "Increase PO intake to >75% 2/3 meals" which was initiated on 03/05/2018 with a target date of 05/22/2018. The following interventions were listed "Provide supplements ordered. Monitor and record intake. Provide, serve diet as ordered. Monitor intake and record q (every) meal. Weigh at same time of day as much as possible and record: weekly." Nutrition note, on the Skin and Assessment document dated 03/05/2018 at 13:46, stated "Current weight: 3/5/18 139# 2/24/18 158.4# Admission weight: 2/22/18 159.4# Resident with 19.4# (12%) weight loss x 1 week. Diet Regular, Regular texture with thin liquids. PO 0-100% (mostly fair). Nutritional supplements include: Health Shake 120 mls at lunch, intake 28%, Propass with pudding at dinner, intake 100% and 2 Cal HN 120 mls BID (twice a day) between meals (added 3/6 for additional 475 kcals and 20 g pro), intake so far 100%. Fluids 680-1360 mls (goal>=1600 mls/d). Last BM (bowel movement) 3/4. Encourage good intake of food, supplements and fluids. Monitor supplement tolerance, intake	4 175	parameters and documenting results in the TAR of PCC. 4. DON/Designee will conduct audits on 3 residents every 2 weeks for one month, then 3 residents per month x 2 months to validate care plans and oxygen parameters are addressed/updated. DON/Designee will report findings to QAA/QAPI committee monthly x 3 months or until a lesser frequency is deemed appropriate. 5. The DON will be responsible for compliance. 6. Compliance will be achieved by 05/08/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING: _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 175	Continued From page 11 and weekly weights." Interviewed Registered Dietician (RD) on 04/06/18, before noon, who confirmed that she should have added significant weight loss % to R15's care plan. It was noted that R15's CP did not list her Ideal Body Weight (IBW) and estimated energy requirements needed to help R15 maintain her weight and at the same time help heal fracture. This information was found in the Nutritional Evaluation done 02/23/2018 at 08:00 by the RD. Lack of identifying the significant weight loss in R15's CP could adversely affect R15 who has multiple health problems causing a deterioration with R15's health. 2) RR of R170's EMR found that he is receiving O2 (Oxygen) by nasal cannula at 0.5 L with a doctor's order to keep O2 saturation below 93%. Review of R170's doctor's orders and CP did not have parameter's stating how low R170's oxygen level can go before notifying his doctor. Interviewed DON on 04/04/18 in AM who confirmed that R170 should have a range for O2 saturation instead of keep O2 saturation below 93%. She was not able to find this in R170's CP. The lack of parameter could adversely affect R170 if his oxygen levels are not maintained at a therapeutic range.	4 175		